		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0007153

Facility Name: Burnside Nursing Home

Address: 410 - 412 North Second Street (Number) Marshall (City) 62441 (Zip Code)

County: Clark

Telephone Number: (217) 826-2358 **Fax #** (217) 826-2367

IDPA ID Number: 37-0841315001

Date of Initial License for Current Owners: September 1963

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(c)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Barbie J. Lachenmayr **Telephone Number:** (618) 546-1573

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2003 to 06/30/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Lonnie Nichols
(Title) Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Barbie J. Lachenmayr, CPA
(Firm Name & Address) 1508 W. Main Street, Robinson, IL 62454
(Telephone) (618) 546-1573 Fax # (618) 544-5434

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Burnside Nursing Home # 0007153 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 105

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	105	Skilled (SNF)	105	38,430	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	105	TOTALS	105	38,430	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,680	11,402	1,600	23,682	8
9	SNF/PED					9
10	ICF	8,640			8,640	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,320	11,402	1,600	32,322	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.11%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 09/01/1963

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 65 and days of care provided 366

Medicare Intermediary Mutual of Ohmaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2004 Fiscal Year: 06/30/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Burnside Nursing Home # 0007153 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	245,156	18,966	5,754	269,876		269,876		269,876			1
2	Food Purchase		154,183		154,183		154,183	(21,119)	133,064			2
3	Housekeeping	72,082	24,381		96,463		96,463		96,463			3
4	Laundry	82,984	15,013		97,997		97,997		97,997			4
5	Heat and Other Utilities			152,575	152,575		152,575		152,575			5
6	Maintenance	61,192	4,421	30,691	96,304		96,304		96,304			6
7	Other (specify):*											7
8	**TOTAL General Services**	461,414	216,964	189,020	867,398		867,398	(21,119)	846,279			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,198,913	140,780	358,148	1,697,841		1,697,841		1,697,841			10
10a	Therapy			246,154	246,154		246,154		246,154			10a
11	Activities	69,064	2,192	2,408	73,664		73,664		73,664			11
12	Social Services	31,763		2,412	34,175		34,175		34,175			12
13	Nurse Aide Training											13
14	Program Transportation			908	908		908		908			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,299,740	142,972	610,030	2,052,742		2,052,742		2,052,742			16
	C. General Administration											
17	Administrative	92,797			92,797		92,797		92,797			17
18	Directors Fees											18
19	Professional Services			32,528	32,528		32,528		32,528			19
20	Dues, Fees, Subscriptions & Promotions			13,351	13,351		13,351	(1,634)	11,717			20
21	Clerical & General Office Expenses	62,503	9,895	56,016	128,414		128,414		128,414			21
22	Employee Benefits & Payroll Taxes			284,918	284,918		284,918	(1,168)	283,750			22
23	Inservice Training & Education			548	548		548		548			23
24	Travel and Seminar			1,592	1,592		1,592		1,592			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			72,812	72,812		72,812		72,812			26
27	Other (specify):*											27
28	**TOTAL General Administration**	155,300	9,895	461,765	626,960		626,960	(2,802)	624,158			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,916,454	369,831	1,260,815	3,547,100		3,547,100	(23,921)	3,523,179			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Burnside Nursing Home #0007153 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			103,262	103,262		103,262	(18,431)	84,831			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,712	27,712		27,712	(27,712)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			130,974	130,974		130,974	(46,143)	84,831			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,921	52,921		52,921		52,921			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			52,921	52,921		52,921		52,921			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,916,454	369,831	1,444,710	3,730,995		3,730,995	(70,064)	3,660,931			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Burnside Nursing Home # 0007153 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(21,119)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(27,712)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(490)	20		28
29	Other-Attach Schedule	(20,743)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (70,064)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (70,064)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Burnside Nursing Home

ID# 0007153

Report Period Beginning: 07/01/2003

Ending: 06/30/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non Care Depreciation	$ 18,431	30	1
2	Employment Recognition	1,168	22	2
3	Patient Subscriptions	296	20	3
4	Other Advertising	848	20	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	20,743		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Burnside Nursing Home # 0007153 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Burnside Nursing Home # 0007153 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number Burnside Nursing Home # 0007153 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Non-Applicable				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$	Non-Applicable		$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Burnside Nursing Home # 0007153 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Non-Applicable								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Burnside Nursing Home # 0007153 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Burnside Nursing Home # 0007153 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Union Planters		X	Mortgage	$4,380.00	8/17/01	$ 394,245	$ 268,004	6/15/10	5.5000	$ 16,648	1
2	Union Planters		X	Line of Credit	LOC	2/6/03	150,000	150,000	8/6/04	5.0000	3,382	2
3	Union Planters		X	Line of Credit	LOC	5/2/03	50,100	45,150	9/19/08	5.2500	289	3
4	First Financial Bank		X	Operating Note	Single Pay Note	12/22/03	125,500	125,500	7/20/04	6.0000	3,941	4
5	ONB		X	Line of Credit	LOC	2/3/03	200,100		2/3/04	4.7500	3,452	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$4,380.00		$ 919,945	$ 588,654			$ 27,712	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 919,945	$ 588,654			$ 27,712	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 16,648 Line # 32

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Burnside Nursing Home # 0007153 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Burnside Nursing Home COUNTY Clark

FACILITY IDPH LICENSE NUMBER 0007153

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Burnside Nursing Home # 0007153 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,819 B. General Construction Type: Exterior Bd fd st / Lime st Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Robert Flowers Village - Independent Living Facility - 8 Units
Burnhaven Apartments - Independant Living Facility - 8 Units
Cork Medical Center - Provides outpatient medical care - Leased to unrelated party

All the above facilities have their own accounting records and share no common cost with Burnside's Nursing Home.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		226,425	1963	$ 22,963	1
2		8,400	1982	12,376	2
3	TOTALS	234,825		$ 35,339	3

Facility Name & ID Number Burnside Nursing Home # 0007153 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1963	1963	$ 823,909	$ 3,323	15,30	$ 3,323	$	$ 798,351	4
5			1995	1995	1,100,822	27,521	30	27,521		245,170	5
6			1997	1997	737,255	18,431	20	18,431		124,433	6
7			1997	1997	(737,255)	(18,431)	20,30	(18,431)		(124,433)	7
8			2002	2002	3,982	199	20	199		338	8
	Improvement Type**										
9	ELEVATOR			1965	8,581		20			8,581	9
10	SAFETY DOORS AND INPROVEMENTS			1972	9,375		10			9,375	10
11	IMPROVEMENTS			1974	4,562		10			4,562	11
12	SPRINKLER SYSTEM			1975	39,041		20			39,041	12
13	IMPROVEMENTS			1977	2,892		10			2,892	13
14	IMPROVEMENTS			1978	636		10			636	14
15	IMPROVEMENTS			1979	11,842					11,842	15
16	AWNING, DINING ROOM WINDOWS			1981	21,654		30-Oct			21,654	16
17	DRAPES, GUTTERING, DRAINAGE WORK			1982	13,093					13,093	17
18	DRAPES			1983	5,526		15			5,526	18
19	DRAPES, LIGHTING & KITCHEN CABINET DOORS			1984	7,163		10,15			7,164	19
20	FIRE SYSTEM KITCHEN, DRAPES, STEEL WALL KITCHEN			1985	25,083	754	5,25	754		24,145	20
21	LIGHTS, CALL SYSTEM, REMODELING, DRAPES, ROOF			1986	67,975	506	5,25	506		67,139	21
22	SPRINKLERS, CARPET, DRAPES			1987	9,272	315	5,25	315		8,490	22
23	BUILDING IMPROVEMENTS, WATER PUMP, SEWER			1988	9,350	449	8,20	449		7,909	23
24	SMOKE DETECTOR, REMODELING, AIR CONDITIONER			1989	31,888	1,449	5,20	1,449		24,014	24
25	DOOR ALARM, FIRE ALARMS, REMODELING			1990	13,402	355	10,20	355		11,308	25
26	REMODELING			1991	5,798	120	10,20	120		4,982	26
27	OFFICE REMODELING DOOR			1993	8,177	642	10,20	642		8,490	27
28	WATER SYSTEM, WINDOR			1994	5,079	352	10,20	352		3,528	28
29	NEW WING ADDITION			1995	88,453	5,224	10,20	5,224		46,207	29
30	WALLPAPER, BLINDS, PHONE SYSTEM			1996	4,335	217	20	217		1,774	30
31	CEILING WORK, INSULATION			1997	24,991	1,249	20	1,249		8,487	31
32	BACKFLOW SYSTEM/SPRINKLER SYSTEM			1998	2,990	150	20	150		911	32
33	ROOFING, REMODELING			1999	41,517	2,124	10,20	2,124		11,670	33
34	DRAPERIES, MAIN DINING ROOM			2000	2,735	273	10	273		1,093	34
35	WINDOWS, DINING ROOM			2000	3,620	241	15	241		945	35
36	SPRINKLER HEAD			2001	560	37	15	37		96	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Burnside Nursing Home # 0007153 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PARKING LOT	1973	$ 19,280	$	10	$	$	$ 19,280	37
38	LANDSCAPING	1974	2,891		10			2,891	38
39	PARKING LOT IMPROVEMENT	1975	3,989		10			3,989	39
40	BLACKTOP SEALING, CULVERT INSTALLATION	1980	13,853		10			13,853	40
41	BLACKTOP AT SHED, SEWER	1981	5,170		15			5,170	41
42	LANDSCAPING, GRADING, PARKING LOT IMPROVEMENTS	1982	15,497		5,15			15,497	42
43	ASPHALT SEALING	1983	3,511		5			3,511	43
44	LANDSCAPING, ROAD IMPROVEMENT	1984	4,350		5,10			4,350	44
45	LANDSCAPING AT CHAPEL	1988	675		10			675	45
46	LANDSCAPING	1989	220		10			220	46
47	ROAD RESURFACINT	1990	9,188	593	5,15	593		8,693	47
48	ROCK	1992	330		10			330	48
49	ASPHALT SEALING	1993	20,570		5			20,570	49
50	LANDSCAPING, FIRE HYDRANT	1995	4,807	294	10,20	294		2,690	50
51	PARKING LOT PAVING	1999	11,850	1,185	10	1,185		7,110	51
52	LANDSCAPING	2000	500	33	19	33		158	52
53	CHAPEL	1985	229,191	7,284	10,30	7,284		149,678	53
54	DRAPERIES AND CARPET	1986	4,252		20			4,252	54
55	ROOF - NEW SHINGLES	2002	3,819	255	15	255		531	55
56	ROOF ON GARAGE	2000	791	53	15	53		199	56
57									57
58									58
59									59
60									60
61	IDPA DESK REVIEW RECLASSIFICATION		18,478	1,432		1,432		16,264	61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,771,515	$ 56,629		$ 56,629	$	$ 1,679,324	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Burnside Nursing Home # 0007153 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 381,687	$ 28,919	$ 28,919	$	10	$ 267,852	71
72	Current Year Purchases	14,295	715	715		10	715	72
73	Fully Depreciated Assets	159,795				10	159,795	73
74		(18,478)	(1,432)	(1,432)			(16,264)	74
75	TOTALS	$ 537,299	$ 28,202	$ 28,202	$		$ 412,098	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	LOCAL TRNSPTN	1981 GMC RALLY VAN	1981	$ 13,873	$	$	$	5	$ 13,873	76
77	LOCAL TRNSPTN	1987 DODGE PICKUP	1987	8,212				5	8,212	77
78										78
79										79
80	TOTALS			$ 22,085	$	$	$		$ 22,085	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,366,238	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 84,831	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 84,831	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,113,507	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$ N/A	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Burnside Nursing Home # 0007153 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits			N/A				6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Burnside Nursing Home # 0007153 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/2004 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 144,638	$	1
2	Cash-Patient Deposits	5,956		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	164,160		3
4	Supply Inventory (priced at)	37,260		4
5	Short-Term Investments	26,250		5
6	Prepaid Insurance	12,943		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 391,207	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	35,339		13
14	Buildings, at Historical Cost	2,665,968		14
15	Leasehold Improvements, at Historical Cost	824,325		15
16	Equipment, at Historical Cost	577,863		16
17	Accumulated Depreciation (book methods)	(2,219,510)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,883,985	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,275,192	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 106,163	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	320,650		29
30	Accrued Salaries Payable	137,451		30
31	Accrued Taxes Payable (excluding real estate taxes)	17,884		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,787		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DEF. REV & TRUST ACCOUNT	6,706		36
37	S-T PORTION OF L-T DEBT	38,803		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 630,444	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	229,201		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DUE TO R.F.V.	290,166		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 519,367	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,149,811	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,125,381	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,275,192	$	48

***(See instructions.)**

Facility Name & ID Number Burnside Nursing Home # 0007153 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,319,865	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,319,865	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(203,484)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (203,484)	17
	B. Transfers (Itemize):		
18	**Interdivisional Transfer**	9,000	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 9,000	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,125,381	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,446,284	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,446,284	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,018	6
7	Oxygen	29,392	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 30,410	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	21,119	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	446	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 21,565	23
	D. Non-Operating Revenue		
24	Contributions	2,057	24
25	Interest and Other Investment Income***	25,565	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 27,622	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Revenue	869	28
28a	Refunds & Rebates	761	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,630	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,527,511	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	867,398	31
32	Health Care	2,052,742	32
33	General Administration	626,960	33
	B. Capital Expense		
34	Ownership	130,974	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	52,921	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,730,995	40
41	**Income before Income Taxes (line 30 minus line 40)****	(203,484)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (203,484)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,042	2,160	$ 59,953	$ 27.76	1
2	Assistant Director of Nursing	1,434	1,559	26,897	17.25	2
3	Registered Nurses	15,268	16,810	272,996	16.24	3
4	Licensed Practical Nurses	15,862	17,688	215,975	12.21	4
5	Nurse Aides & Orderlies	73,354	79,540	574,286	7.22	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,309	4,822	48,806	10.12	8
9	Activity Director	2,080	2,080	23,172	11.14	9
10	Activity Assistants	5,539	5,795	45,892	7.92	10
11	Social Service Workers	2,198	2,241	31,763	14.17	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,420	25,876	10.69	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,774	26,905	219,280	8.15	15
16	Dishwashers					16
17	Maintenance Workers	4,851	5,321	61,192	11.50	17
18	Housekeepers	9,480	10,297	72,082	7.00	18
19	Laundry	9,065	10,058	82,984	8.25	19
20	Administrator	2,847	2,969	92,797	31.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,004	2,139	28,064	13.12	23
24	Clerical	3,873	4,215	34,439	8.17	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	181,060	197,019	$ 1,916,454 *	$ 9.73	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	42	$ 5,754	1-3	35
36	Medical Director	Mo Fee	1,055	10-3	36
37	Medical Records Consultant	Mo Fee	861	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	100	1,000	10-3	39
40	Physical Therapy Consultant	Mo Fee	98,410	10A-3	40
41	Occupational Therapy Consultant	Mo Fee	106,322	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Mi Fee	41,422	10A-3	43
44	Activity Consultant	70	2,408	11-3	44
45	Social Service Consultant	70	2,412	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	282	$ 259,644		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	20	$ 974	10-3	50
51	Licensed Practical Nurses	1,548	68,110	10-3	51
52	Nurse Aides	6,964	201,610	10-3	52
53	TOTAL (lines 50 - 52)	8,532	$ 270,694		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jackie Williams	Former Admin.	0	$ 65,473
Lonnie Nichols	Administrator	0	27,324
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 92,797

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Larson,Woodyard & Henson	Accounting	$ 10,990
Dimond Financial Consultants	Accounting	12,475
Duane,Morris & Heckscher, LLP	Legal Services	4,506
Larson,Woodyard & Henson	Computer Services	4,557
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 32,528

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 71,744
Unemployment Compensation Insurance	6,220
FICA Taxes	132,030
Employee Health Insurance	71,506
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Flex Administration	2,250
TOTAL (agree to Schedule V, line 22, col.8)	$ 283,750

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
General Advertising	4,803
Fees	623
Dues & Subscriptions	7,714
Marketing Expense	211
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,351

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,592
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,592

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Burnside Nursing Home # 0007153 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4		N/A											
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Burnside Nursing Home **#** 0007153 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IHCA 5,670**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **32,587** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **52,921**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **NONE** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NONE** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **Barbie J. Lachenmayr, CPA** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.